Medina County
board of developmental disabilities

Family Support Services

Purchase Reimbursement Form

Parent/ Guardian (please print) _____

Enrollee_____

Address _____ Phone Number _____

City _____ State _____ Zip Code _____

Store/ Vendor	Product Description	Cost

Total _____

Less Co-Pay of _____

_____

Parent/Guardian Signature

Please attach original/scanned/emailed receipts and return within 60 days of purchase to:

Medina County Board of Developmental Disabilities
Attn: Medicaid Services Manager
4691 Windfall Road
Medina, Ohio 44256

or fax to 330-722-4854
or email FSSinfo@mcbdd.org

Please take a moment to answer the survey question. This information will help us with future planning.

What suggestions do you have to improve the FSS program? _____

_____

_____

FOR OFFICE USE ONLY

Amount of Co-Pay $ _____

Amount to Be Reimbursed to Family $ _____

Business Office Approval Date _____

Allotment Balance $ _____

MCBDD-SSA
Rev: 11/18/21-SP V: 2
0309051
RC-2: R-69
Proc Ref: 722 Family Support Services
Policy Ref: MCBDD Policy Ch. 7, Sec. 6